

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/20/2013
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND		STREET ADDRESS, CITY, STATE, ZIP CODE 615 N MICHIGAN ST SOUTH BEND, IN 46601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00119836 Unsubstantiated: lack of sufficient evidence</p> <p>Date: 02/20/13</p> <p>Facility Number: 005053</p> <p>Surveyor: ReBecca Lair, LCSW Medical Surveyor</p> <p>Memorial Hospital of South Bend is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Hospital Licensure Rules.</p> <p>QA: claughlin 04/16/13</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1